DOWSETT CHIROPRACTIC HEALTH CENTER
Dr. Timothy J. Dowsett, D.C.

PATIENT REGISTRATION

Date _____

Name: _____ Occupation: _____

Address: _____ Employer: _____

City, State: _____ Address: _____

Zip Code: _____ Home # (___) _____ City, State, Zip: _____

Cell # (___) _____ Work # (___) _____ EMPLOYMENT STATUS

Soc. Sec. # _____ ☐ Male ☐ Female Employed: ☐ Full time ☐ Part time ☐ No
Student: ☐ Full time ☐ Part time

Birth Date: _____ Age: _____

Race: _____ Ethnicity: Latino or Hispanic _____ Non- Latino or Hispanic _____

Preferred Language _____ Email Address _____

MARTIAL STATUS: Single Married Separated Divorced Widow

Guarantor (if minor) _____ Phone (___) _____
Address _____ City, State, Zip _____
Soc. Sec # _____ Date of Birth _____
Employer _____ Phone# (___) _____

Primary Insurance _____
Policy Holder Name _____ Date of Birth of Policy Holder _____

Secondary Insurance _____
Policy Holder Name _____ Date of Birth of Policy Holder _____

Emergency Contact _____ Phone (___) _____
Relationship to Patient _____

I hereby authorize Dowsett Chiropractic to release any medical or appointment information to the following persons: (i.e- spouse, parents, children, or significant other)

Name Relationship

_____

_____

Signature of Patient / Guarantor _____ Date _____